Barker (B. Ford.)

LECTURES

ON

UTERINE DISPLACEMENTS,

BY

B. FORDYCE BARKER, M. D.,

PROFESSOR OF MIDWIFERY AND DISEASES OF WOMEN IN THE NEW YORK MEDICAL COLLEGE.

REPORTED BY B. T. ROATH, M. D.

LECTURE FIRST.

[From the New York Medical Gazette.]

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Prolapsus of the Uterus.

Gentlemen:

I propose to study with you, previous to the commencement of our regular course on mdwifery and diseases of women, the subject of Uterine Displacements. I have selected this subject, because it seems to me that the tendency, at the present day, is to overlook and neglect this important class of affections. It is overshadowed in the study of the inflammatory affections of this organ.

The great value and importance of the advances that have been made in the diagnosis and pathology of Uterine Disease, especially the inflammatory affections of this organ and its appendages, cannot be too highly estimated. But there is danger that old facts and old truths may be forgotten in the zealous pursuit of the new.

Displacement in some form or other is a very common affection. Indeed, some of the older writers regard it as the most frequent of all the chronic diseases to which women in civilized society are liable. The symptoms

which arise from displacements are very numerous, extremely variable, and frequently rebellious to treatment. These symptoms are such as are common to a great variety of different affections of the uterus. Thus, menorrhagia, dysmenorrhea, leucorrhea, bearing down pains, rectal and vesical tenesmus, etc., indicate that there is some uterine trouble; but none of these general symptoms are characteristic of any one particular affection. Professor Simpson, of Edinburgh, has well expressed the truth, that there are a great number of general symptoms which indicate that the uterus or its appendages are the seat of disease, but none which are pathognomonic of the particular disease, in the following proposition: "The general and local, functional symptoms of disease of the uterus are such as to enable us to localize, without enabling us to specialize, the exact existing affection of the organ." The medical man, therefore, who would diagnosticate inflammation or ulceration, or any other disease of the cervix on the one hand, or prolapsus or retroversion on the other, from the rational symptoms alone, would be utterly at fault. So then, in studying the subject of uterine displacement, we shall necessarily be obliged to study carefully, not only all the functional symptoms of uterine disease, but also all the signs derived from the improved methods of physical exploration.

In order to appreciate the symptoms arising from displacement of the uterus, we must be thoroughly acquainted with its normal position. I shall therefore

detain you, for a few moments, with a brief description of the uterus and its anatomical relations in the cavity of the pelvis.

[The anatomical description of the uterus and its relations we omit.—*Rep.*]

Any change of position by which the uterus loses its place in the centre of the pelvis, with the bladder before and the rectum behind it, and its long diameter corresponding with the axis of the brim, is a displacement. But some displacements are physiological, as the *descent* of the uterus in the early months of pregnancy, its *ascent* in the latter months.

The pathological displacements are—*prolapsus*, that is, a depression of the uterus below its natural level in the pelvis; *retroversion*, where the fundus falls below the promontory, down into the hollow of the sacrum, at the same time the cervix rises up behind the symphisis pubis; *anteversion*, where the fundus falls forward towards the pubis, the cervix being directed backwards towards the sacrum, the uterus, as in retroversion, occupying a transverse position in the pelvis. On the table before you, you see models representing each of these displacements, and also two other forms of displacement, in which the *cervix* retains its normal position, but the uterus is bent upon itself—backwards in the one, *retroflexion*—anteriorly in the other, *anteflexion*.

By far the most frequent variety of these displacements is prolapsus. It occurs most frequently in females beyond the middle age, who have borne children; but it

is also met with in all ages, and in virgins. Several instances are even reported of its occurrence in children. Every degree of variety may be met with, from the case where the uterus only settles down lower into the middle of the vagina, which enlarges to afford lodgment for it, to the case where it projects in the vulva, dragging the vagina with it, and forming a tumor between the thighs. Different terms have been used by authors to indicate these degrees, as *relaxation*, delapsus, prolapsus, procidentia, etc.; but these terms, as indicating the degree of descent, have only been productive of confusion, as the second degree is called procidentia, and the third degree prolapsus by some, while others call the second degree prolapsus, and the third, procidentia.

Nearly all authors make three degrees of prolapsus: 1st, where the uterus loses its proper level in the pelvis, the cervix resting on the perineum, the vaginal canal being somewhat shortened, but without any change in the direction of the uterine axis; 2d, where the uterus has sunk nearly or quite to the os externum, the upper half of the vagina being everted, like the finger of a glove with its top thrust inward, the axis of the uterus no longer corresponding with the axis of the brim, but being in the direction of the axis of the outlet of the pelvis; 3d, where there is complete protrusion of the uterus beyond the vulva, the uterine tumor being covered by the vagina, which is completely turned inside out.

Perhaps the least objectionable and most significant terms, as applied to these degrees of prolapsus, are

those employed by Dr. Herring, the translator of Boivin & Duges' work on Diseases of the Uterus. I shall, therefore, use the terms, *incipient-prolapsus*, *semi-prolapsus* and *complete prolapsus*.

It is of great importance to understand the *causes* of prolapsus, in order to judge correctly as to its appropriate treatment. The principal causes assigned by authors are, 1st. Increased capacity and relaxation of the vagina; 2d. Weakness and undue expansion of the broad and round ligaments of the uterus; 3d. Augmentation of the volume and weight of the uterus.

There has been a great diversity of opinion among authors as to the causes. Lisfranc, Cruveilhier, Bennet, and others, are disposed to ascribe prolapsus solely to increase of weight of the uterus. Others refer it wholly to relaxation or diminished power of the suspensory ligaments of the uterus. On the other hand, most ingenious and conclusive arguments have been urged by different authors against each of these causes; so that, taking all their arguments together, there should be no such thing as prolapsus known. One believes that relaxation of the vagina cannot be a pathological cause of prolapsus, because the vagina is an organ susceptible of development to an almost indefinite extent, and can scarcely have been intended to maintain a degree of contractedness sufficient to enable it to sustain the uterus in any given position, and because the vagina is actually the most ample where, if the vagina is to support the uterus, it should be the most contracted. Others assert that relaxation of the uterine ligaments is the effect of prolapsus and not

its cause. Professor Burns and Dr. Ashwell, found by experiment on the dead body, that by cutting the ligaments the uterus could not be made to protrude without much force. Again, it is asserted by others, that there is frequently marked increased weight of the uterus, without any proportionate descent of the organ.

These objections may all hold good against any exclusive view as to the cause of prolapsus. But Vidal is undoubtedly correct in referring the causes to the three following orders:

1st. Those which refer to the state of the vagina and pelvis;

2d. Those which refer to the attachments of the uterus, viz. the ligaments;

3d. Those causes inherent to the uterus itself.

A large pelvis, with a capacious, lax vagina, itself disposed to prolapsus, singularly predisposes the uterus to prolapse.

The uterine ligaments, like all other ligaments, may become relaxed. They may become enfeebled by repeated pregnancies, or by changes in the constitution of the woman.

All that which augments the volume or weight of the uterus, operates, sooner or later, in effecting a change in the situation of the uterus. Thus, fibrous tumors, cancers, polypi, inflammations, or other lesions of the cervix, may produce a change in the position of the uterus.

Of the *predisposing* causes, by far the most common is too early resumption of the erect posture after labor. During gestation, the ligaments of the uterus are for a

long time greatly elongated. At the time of labor, the vagina is greatly distended by the passage of the fœtus. During gestation, the uterus increases in weight from two ounces to twenty-five or thirty ounces. After delivery, it requires from four to eight weeks for it to return to its normal size in the unimpregnated condition.

Here, then, we have in gestation a physiological preparation for the three pathological causes which we have mentioned of prolapsus.

During *menstruation*, also, the uterus, and in fact, all the sexual organs are physiologically congested. There is increased weight of the uterus, the ligaments are stretched, and therefore weakened, the vagina is also congested, and therefore relaxed. So at this period, any severe exercise, as lifting a heavy weight, dancing, running, etc., may produce displacement.

I am thoroughly convinced, that it is much more common, owing to this cause, among unmarried females, even young girls, than is usually believed or suspected.

Prolonged leucorrhea has been assigned as one of the predisposing causes of prolapsus; but here, it seems to me, a coincident symptom of some other pathological condition has been mistaken for a cause.

Those accustomed to treat uterine disease, have observed that the inflammatory diseases of the cervix are almost invariably attended with a prolapsed condition of the organ. Dr. Bennet is perhaps too exclusive in his views, as to the inflammatory diseases of the cervix being the principal cause of prolapsus. But the fact cannot be doubted, that it is usually accompanied by more or less

descent of the organ, and that it rises higher and higher in the cavity of the pelvis as the inflammatory affection progresses towards a cure.

The *symptoms* arising from prolapsus are by no means proportionate to the degree of the descent of the organ, but depend in a great measure upon the susceptibility of the individual. A delicate, irritable woman, will suffer much more from a semi-prolapsus than a hardy, robust woman, accustomed to active exertion, will suffer from complete prolapsus of the organ. The symptoms are partly mechanical, arising from pressure upon the other organs within the pelvic cavity, and partly sympathetic.

The symptoms of *incipient* prolapsus do not appear suddenly, but gradually. There is a dragging pain in the loins and over the sacrum, increased by any exertion in walking, or even by standing. Pain is also felt in the groin, sometimes extending to and terminating in the labia. This is due to the stretching of the round ligaments. Leucorrhea is almost a constant symptom. This may arise from the excitement produced in the muciparous glands of the vagina, by the irritation of the cervix pressing upon them, or to the associate disease of the cervix. Strangury is sometimes complained of, and indicates more or less inflammation of the prolapsed cervix and the parts contiguous to it. The function of menstruation is said to be rarely suspended in the majority of cases. However, I do not think this is true as regards young women. In them incipient prolapsus is generally accompanied by scanty menstruation, and sometimes

complete amenorrhea. In some rare cases, there is the opposite condition, viz. menorrhagia. When the symptoms I have just mentioned have existed for a long time, you may expect to find the patient complaining of nausea, loss of appetite, flatulence, and constipation. On a vaginal examination, the cervix will be found within an inch or two of the orifice, and resting on the perineum, which it ought not to touch. The vagina is generally moister than natural, loose and flabby, or smoother and less corrugated than usual.

Incipient prolapsus may be confounded with early pregnancy, or with congenital elongation of the neck, or with polypus. In the earliest period of pregnancy, the uterus, obeying the laws of gravity, sinks down into the cavity of the pelvis. The fundus falls a little backwards towards the sacrum, while the cervix approaches or comes in contact with the perineum, and is directed forward. But the absence of the functional derangements of pregnancy, and the presence of the other symptoms which I have just enumerated, will leave little liability to mistake early pregnancy for incipient prolapsus.

In certain females the cervix normally projects more than an inch into the cavity of the vagina. But this condition is not attended with the lumbar and inguinal pains, or indeed any of the other symptoms of depression, except, perhaps, occasional rectal or vesical tenesmus.

Cases are recorded where incipient prolapsus has

been mistaken for polypus. I met with one in a young woman who had been married some eight months. Menstruation was irregular, profuse and painful. The cervix was greatly engorged, pressing on the perineum, and within an inch of the external orifice. Her ordinary medical attendant had probably made a hasty, careless examination, and pronounced the case one of polypus. Moreau relates a case nearly the opposite of this. A young woman of twenty was sent to him from the provinces, on account of a supposed prolapsus. He found a polypus, which he removed by ligature. Polypus is ordinarily accompanied by a sanguineous discharge, prolapsus by a leucorrheal discharge. The inferior extremity of the polypus is the largest. This fact, and the absence of the os tincæ, will be sufficient to determine the difference between the two.

The diagnosis of incipient prolapsus is by no means complete on ascertaining that the organ is depressed. However, I will reserve what I have to say on this point, until I come to speak of the treatment.

The symptoms of semi-prolapsus are only an exaggeration of those first described. The long diameter of the uterus corresponds with the axis of the outlet. The uterus compresses the rectum and the bladder, and there is frequently difficulty in evacuating these organs. Obstinate constipation from a mechanical cause is not unusual. The strangury arising from this, as remarked by Sir Charles Clark, differs from that

arising from other causes, in that it goes off when the patient lies down.

In complete prolapsus, the uterus has become an external tumor, covered by the vagina. The bladder is turned backwards and withdrawn from the pressure of the abdominal muscles, so that it is evacuated with difficulty and incompletely. The mucous membrane of the vagina covering the uterus, loses its distinctive power as mucous membrane, becomes dry, and resembles skin. By the friction of the thighs, the clothes, etc., the surface becomes excoriated, and superficial ulcerations take place. In some cases inflammation is excited, which results in gangrene and separation of the uterus. The general symptoms of complete prolapsus are often much less severe than those occurring in semi-prolapsus.

The treatment of this form of uterine displacement has afforded a rich harvest for charlatans and quacks. Females who have suffered from "bearing down," and pain in the back, are easily led to believe that they have "falling of the womb;" and large fortunes have been made by more than one in this city, I am told, by the sale of "body braces" and "supporters." Works have been written and extensively circulated among the public, referring a great variety of disorders and symptoms to a mechanical origin; and this seems to be a very *taking* theory, if I may judge by the number of females who have come to me with their abdomens enveloped in steel frames. Still, this af-

fection, when it exists, merits more attention than it has received from most practitioners. There is no doubt that it is generally treated too empirically, by even the well-informed and judicious physician.

If Sir Charles Clark's remark, "that if nothing were done in the way of treatment, a patient laboring under this disease might die from weakness, induced by the large discharges and the disordered state of the stomach; or she might die from inflammation taking place in the parts contained in the inverted vagina, which are more liable to pressure than when in their usual place," be not confirmed by the general experience of the profession, still the evils of this disease are of sufficient magnitude to demand an earnest effort for their effectual removal. The established treatment of most systematic authors may be comprised of two methods: medicinal means applied to the mucous membrane, with rest in the horizontal position, in the milder cases; and mechanical support, in the more severe cases;—the first effected by the injections of cold water, and the various vegetable and metallic astringents; the second, obtained either by external appliances, called "supporters," which take off the weight of the abdominal viscera and increase the resistance of the perineal muscles, or by instruments made of various materials, and of various forms, introduced into the vagina, called "pessaries." I shall detain you with only a word of comment on these methods of treatment.

First, I will admit that some cases get well under each of these plans; but all must agree that a successful radical cure by these methods, is the exception and not the rule. Neither the horizontal posture, rigidly adhered to for a long time, nor astringent injections, can restore the tone of the ligaments; and both of these means are liable to induce obvious evils. I have known more than one case where the general health has been seriously injured by a protracted adherence to the recumbent posture. The supporter doubtless relieves from many of the distressing symptoms of this affection; but I have never known a cure effected by one; and the idea of compelling a young wife to wear such a harness all her life, is anything but attractive. The advocates of pessaries assert that they often do cure; but they must admit that this is not the case in a majority of instances, and that their use is often attended with great inconvenience, and has frequently resulted in serious evils. Notwithstanding the ingenious arguments with which Churchill meets the various objections which have been urged against the use of pessaries, I must still reproduce those which others have urged—viz. that they are merely palliatives, and, like other palliatives, tend to perpetuate the necessity of their application during the life of the patient; that they distend the flooring of the pelvis, and increase the capacity of the ano-perineal region, thus directly aggravating one essential and important

element of the disease; that they provoke mucous discharges from the vagina where they do not exist, and change the character and quantity of existing ones much for the worse; that they cannot be worn by many, on account of the local and constitutional irritation they produce; that they occasionally produce serious and even fatal inflammations; that they interrupt sexual intercourse; that their proper application, and the choice of their form and dimensions so as to adapt them well to each case, is so difficult as to seriously embarrass most practitioners; and that, in numerous instances, pessaries have become so encrusted and firmly embedded in the vagina, as to require a serious operation for their extraction. It is no answer to the last objection, to say that it can only happen from gross neglect; for the neglect may be on the part of the patient instead of on the part of the physician. In fact, I believe that most of these cases have occurred where the patient has removed from the observation of the physician who has applied the instrument; and hence the force of an objection urged by Professor Hamilton, that they subject the patient to the charge of the medical attendant for life.

I shall now call your attention to a plan of treatment on which I have relied for eight years, and which I hope you, as you have opportunity, as have several of my friends, will subject to the test of experience.

I shall say nothing now in regard to preventive

treatment, or dwell upon the necessity of insisting upon the recumbent position after confinement, in those who have previously suffered from "prolapsus," as this will more properly be embraced in my lectures on "midwifery proper."

In the beginning of the lecture, following Vidal, I divided the causes of prolapsus into those inherent to the uterus itself (that is, all those causes which augment the volume or weight of the uterus), those which refer to the state of the vagina and pelvis, and those which refer to the attachments of the uterus. I have said nothing in regard to the doctrine of M. Retzius, who rejects all these causes, and ascribes prolapsus to the distention, by the descent of the bowels, of the inflections of the peritoneum, which are to be found on each side of the womb; because his arguments, to my mind, carry but little weight with them.

Now, the indications for cure must be based on the causes which produce the displacement. Prolapsus, resulting solely from the condition of the uterus itself, usually, I think, subsides spontaneously when the uterine trouble is removed. I have often found the uterus very low in the pelvic cavity when there is inflammatory disease of the cervix, but rising higher and higher during the treatment. I may add that, so far as my experience goes, this is a much more frequent cause than both the others; but it is to prolapsus depending upon the other causes to which

I wish now more especially to call your attention. That there are causes entirely independent of the weight of the uterus, I am perfectly certain; as I have in several instances seen *complete prolapsus* where the uterus was evidently atrophied. Admitting then, both the causes before mentioned, the indications for cure will be, 1st, to retain the uterus in its normal condition; 2d, to diminish the preternatural capacity of the vagina; and 3d, to restore tone to the ligaments. The first is gained by mechanical means, the second by astringents, and the third by fulfilling the first two, and increasing the general vital powers. Very slight support suffices to fulfil the first. I have rarely found any evil resulting from the attempt to accomplish the second, such as injury to the general health from arrest of the accustomed discharges, or inflammation or irritation of the mucous membrane of the vagina. The method which I adopt is the following: I cut out a double thickness of patent lint of a triangular form, so that when rolled up it will form a cone, of a size adapted as nearly as I can judge to the capacity of the vagina. Half an inch from the apex is firmly tied a piece of narrow bobbin, for the purpose of facilitating withdrawal. This is soaked in a saturated solution of tannin. The patient being placed upon her back, the uterus is replaced, care being taken to adjust it so that its axis corresponds with the axis of the superior strait, and the lint introduced with

the apex first; but after it is in the vagina it is turned, so that the base will come under the os tincæ. This is withdrawn, and a new one introduced, twice in the twenty-four hours. In some cases there is soreness and tenderness of the vagina, when I add to each ounce of the solution of tannin ʒii of laudanum. I have used morphine, but the laudanum seems to be more efficient in removing the soreness. The size of the lint pessary is gradually diminished until the base is not more than half an inch in diameter, when the cure may be considered as accomplished. This should never be left for the patient to do herself. It requires the personal attendance of the physician. The patient will not do it properly or efficiently. You will surely be disappointed if you trust her. If she have means, she will not demur at paying for all the trouble you are at in effecting a cure; if she be poor, you will be amply repaid in seeing her able to perform her duties in life with comfort and ease.

This is a very different mechanical support from the sponge, which expands in the vagina, or any unyielding pessary, or even the sachet "filled with finely grained, not pulverized, Aleppo galls," of which Professor Meigs speaks. This *contracts* in the vagina. It, so to speak, *packs* in the vagina, so that when you withdraw it, you will find it much smaller than when you introduced it. Indeed, I am sure you will be surprised to find how rapidly you are obliged to diminish the size of the lint. But

local treatment is not all that is necessary. I need hardly say that, previous to commencing this treatment, the bowels should be thoroughly evacuated, and that during the whole treatment they should be kept *well opened*. Every man of tact and discrimination will adopt his general treatment to the peculiarities of his patient. Many of this class require tonics. To some I have given three times a day two grains of quinine, in a wine-glass full of the solution of the citrate of magnesia. To others I have given the tart. or the citrate of iron in the same solution. Some I have given the iodide of iron, and recently I have been greatly pleased with the effects of the manganese as a tonic. All do not require tonics. But above all things keep the bowels open, and even after you cease attendance, threaten your patient with all the terrors of a relapse, if she do not keep her bowels open.

Formerly I used to direct my patients to keep the recumbent posture during the first week of treatment; but on finding that my poor patients, who were obliged to keep about, got along better than those in better circumstances, I have now adopted a different course, and send them out into the open air as much as possible, from the beginning.

This mode of treatment is applicable to each of the different degrees of prolapsus. I have before remarked that the symptoms, where there is but slight depression, are quite *as* severe in some, as those attending complete prolapsus are in others. I have several times been led

to suspect, from the severity of the symptoms complained of, that inflammatory disease of the cervix existed; but a careful examination with the speculum revealed no disease. The pain in the back, nausea, fever, vaginal irritation, and constipation, were the result of the depression. Lisfranc declares that all cases of incipient prolapsus are caused by congestion. He directs that the congestion of the uterus should be first treated, and if after that the displacement of the womb continues, the pessary may be applied if the patient can bear it. Now, the lint and tannin pessary applied in the manner in which I have directed, relieves this condition of things at once. To borrow an illustration from Dr. Meigs, it acts like a suspensory in the treatment of orchitis.

In complete prolapsus, you will be able to use this means of treatment when no other form of pessary can be retained or worn. Sometimes it will be necessary for the patient to wear for a time a perineal bandage, but this is not often the case. Please to try this method, and see if you cannot in all cases effect a radical cure. I believe you can, in all cases excepting those where the sacrum is very straight, and there has been great loss of the substance of the perineum.

I could give you the history of many cases of complete prolapsus, where a perfect and radical cure has been effected by this plan. A widow, aged thirty-two, cook for a large and fashionable boarding-house in University Place, had the uterus entirely protruded from the vagina. She was obliged to wear a napkin constantly, to keep

the uterus within the vulva. It protruded at once on removing the napkin. She was cured in two months, by the plan I have described. Soon after, she married a waiter in the house. The third of July she went on a steamboat excursion, and danced a good deal. I was called to see her on the fourth, on account of a severe flooding; and she miscarried with a five-month fœtus. She resumed her duties as cook within a week, but there was no return of the prolapsus.

An old lady, sixty-eight years of age, residing in Columbia street, had suffered with complete prolapsus for more than twenty years. Various kinds of pessaries had been at different times adjusted by men of eminence in this city, but for five years she had been unable to wear any. I found her in bed—where she passed the greater part of the time—the uterus small, but the whole tumor external to the vulva, formed by the uterus, vagina, part of the bladder, and part of the rectum, was as large as the egg of a goose. If the tumor was pushed back while lying on her back, it immediately returned. The mucous membrane of the vagina was superficially ulcerated in two places, in one to the size of a twenty-five cent piece, and the other considerably smaller. The cure was effected in three months. The last time I saw her, she said that there was no tendency to falling; and she had left off for some weeks the perineal bandage which I had made for her.

I am often asked, by friends with whom I have conversed in regard to this plan of treatment, if I have never

met with evil consequences from the suppression of the profuse discharge which usually attends the prolapsus? I have, two or three times, but not within the last five years. Formerly I was less careful than now, to use laxations *freely* during the whole course of treatment.

In my next lecture I shall ask your attention to the subject of *retroversion* of the non-gravid uterus.